topdown dental
Nancy Nehawandian, DDS
healthy mouth healthy body healthy life

250 Blossom Hill Road Suite 100
Los Gatos, CA 95032
(408) 354-5600
www.topdowndental.com

1. Name: _____ Date: _____

I. TMJ HISTORY

2. How important is it to you that our office practices Holistic and Biological dentistry?

_____

_____

_____

_____

3. Please Answer the following Questions

	Yes	No
Do you have a burning or painful sensation in your mouth?	Yes	No
Do you get popping, clicking, or grinding noises when you open or close?	Yes	No
Do you ever awaken with an awareness of your teeth or jaws?	Yes	No
Have you ever been told you grind your teeth during sleep?	Yes	No
Do you trouble opening your mouth widely?	Yes	No
Do you feel your bite is different, unstable or uncomfortable?	Yes	No
Do you feel like your sense of balance has changed?	Yes	No
Do you have nasal congestion or difficulty breathing through your nose?	Yes	No
Have you been diagnosed with migraine or tension headaches?	Yes	No

4. Are you aware of clenching during the daytime? How often? _____
○ Yes ○ No

Does your jaw ever lock open or closed? How often? _____
○ Yes ○ No

Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? _____
○ Yes ○ No

5. Do you or have you had any pain in any of the following areas? (Check all that apply)

- ☐ Ear
- ☐ Face
- ☐ Head
- ☐ Jaw
- ☐ Neck
- ☐ Teeth
- ☐ None
- ☐ Other:

If other, please specify:

_____

6. What professional advice or treatment have you had regarding your TMJ, headache or pain conditions/problems?

_____

_____

_____

_____

7.

	Yes	No
If you sought treatment for a TMJ problem, did it help?	Yes	No
Do your jaw problems affect your ability to work?	Yes	No
Has your diet changed due to your jaw problems?	Yes	No
Do you joint noises affect others while eating?	Yes	No

8.

	Yes	No	If yes, specify when
Have you ever been injured in an accident?	Yes	No	
Have you ever had a severe blow to your head?	Yes	No	
Are you aware of stiff neck muscles? (specify how often)	Yes	No	
Have you ever been in traction for a neck injury?	Yes	No	
Have you ever had or been advised to have neck surgery?	Yes	No	
Have you ever been diagnosed with Trigeminal Neuralgia or Bell's Palsy?	Yes	No	

II. FAMILY HISTORY

9. Have any members of your family (blood kin) had:

Heart Disease	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Sleep Apnea	Yes	No
TMJ Disorder	Yes	No

III. SOCIAL HISTORY

10. How often do you have an alcoholic drink?

How often do you take sedatives?

How often do you consume caffeine?

Do you smoke/use chewing tobacco? How much?

IV. SLEEP, SNORING AND APNEA HISTORY?

11. Have you been diagnosed or treated for a sleep disorder?
○ Yes ○ No

When?

Do you become easily fatigued?
○ Yes ○ No

At what time of day?

Do you sleep well?
○ Yes ○ No

How long?

Do you dream?
○ Yes ○ No

How often?

Do you have trouble falling asleep or staying asleep?
○ Falling Asleep ○ Staying Asleep ○ Both

12.

Do you have problems with insomnia?	Yes	No
Do you snore or have you been told you do?	Yes	No
Do you wake up with a headache?	Yes	No
Have you had chronic sleepiness, fatigue or weariness that you can't explain?	Yes	No
Do you often fall asleep reading or watching television?	Yes	No
Have you fallen asleep during the day against your will?	Yes	No
Have you had to pull off the road while driving due to sleepiness?	Yes	No
Have ever been more irritable and short tempered?	Yes	No
Have you felt that your memory and/or intellect are impaired?	Yes	No
Have you been told that you stop breathing while asleep?	Yes	No

13. About how many times per night do you wake up? _____

What time do you normally go to bed? _____

Get up in the morning? _____

Of the hours you are in bed, about how many hours are you asleep? _____

Would you rate the quality of your sleep as:
○ Good ○ Fair ○ Poor

Present Body weight? _____

Height? _____

V. The Epworth Sleepiness Scale

14. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	Chance of Dozing		Chance of Dozing
Sitting and reading		Watching TV	
Sitting inactive in a public place (e.g. A theater or a meeting)		As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit		Sitting and talking to someone	
Sitting quietly after a lunch without alcohol		In a car, while stopped for a few minutes in traffic	

VI. STOP-BANG Scoring Model

15. Check the Box if your answer is yes to any of the following questions:

- ☐ Snoring (Do you snore?)
- ☐ Tired (Do you often feel tired, fatigued, or sleepy during the daytime?)
- ☐ Observed (Has anyone observed you stop breathing during your sleep?)
- ☐ Blood Pressure (Do you have or are you being treated for high blood pressure?)

16. High Risk of OSA if answered Yes to two or more items above. (Out of above 4 questions)

17.

- ☐ BMI (BMI more than 25)
- ☐ Age over 40 years old
- ☐ Neck circumference greater than 16 in (40cm)
- ☐ Gender male

18. High Risk of OSA if answered Yes to three or more items above. (Out of above 8 questions)

VII. ONLY IF APPLICABLE

19. Have you ever had an evaluation at a sleep center?

- ○ Yes
- ○ No

20. If yes:

Sleep Center and Location: _____ Sleep Study Date: _____

What professional advice or treatment have you had regarding your snoring or sleep apnea?

_____

_____

If you sought treatment for a sleep disorder, did it help?

○ Yes ○ No

21. Do you wear a CPAP device successfully during sleeping?

- ○ Yes
- ○ No

If yes, how many hours?

_____

22. If you have attempted treatment with a CPAP device, but could not tolerate it, please check below reasons for your difficulty.

- ☐ Mask Leaks
- ☐ I was unable to get the mask to fit properly
- ☐ Discomfort caused by the straps and headgear
- ☐ CPAP restricts movement during sleep/Unconscious need to remove CPAP at night
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs my sleep and/or bed partner's sleep
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ CPAP does not seem effective
- ☐ Latex allergy
- ☐ Other:

If other, please specify:

_____

VIII. WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Order: Please number the complaints with #1 being the most important. (List all please)	**Frequency:** Please rate your chief complaint as follows: 1=Occasional 2=Frequent 3=Constant	**Intensity:** Please rate your chief complaint on a scale from 0-10. 0=No pain to 10= Most severe pain

23.

Chief Complaint	ORDER	Frequency	Intensity
Jaw clicking/popping			
Jaw joint noise			
Jaw locking			
Muscle twitching			
Limited mouth opening			
Dizziness			
Generalized Headache (Entire head)			
Frontal Headache (Front of your head)			
Occipital Headache (Back of your head)			
Temporal Headache (In your temples)			
Visual disturbances/blurred vision			
Jaw pain			
Facial pain			
Ear pain			
Back pain			
Eye pain			

Neck pain			
Shoulder pain			
Pain when chewing			
Throat pain			
Ear congestion			
Sinus Congestion			
Ringing in the ears			
Fatigue			
Frequent heavy snoring			
Snoring which affecting sleep of others			
Significant daytime drowsiness			
Stop breathing when sleeping			
Difficulty falling sleep			
Gasping when waking up			
Nighttime choking spells			
Feeling un refreshed upon waking			
Morning hoarseness			
Swelling in ankles or feet			

24. For office use only

IX. Please Answer the following Questions

25. When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

X. ONLY IF APPLICABLE

26. Are you involved in a lawsuit regarding your condition?

- ○ Yes
- ○ No

27. If you have an attorney representing you, please complete the following:

Attorney's/Paralegal Name: Phone Number:

Address:

XI. OTHER PROFESSIONALS

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list primary physician and family dentist. Please initial if you want us to send them a report from your visit.

28.

	Name	Phone		Name	Phone
FAMILY PHYSICIAN			DENTIST		
CHIROPRACTOR			PHYSICAL THERAPIST		
EAR, NOSE AND THROAT			CARDIOLOGIST		
ALLERGIST			NEUROLOGIST		
PSYCHIATRIST			PSYCHOLOGIST		
SLEEP SPECIALIST			OTHER:		

If other, specify type:

29. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE,

Patient /Guardian Signature:

Signature Date